Army
Medical Holdovers
Community-Based
Health Care Initiative
(CBHCI)

Medical Holdovers
Three models of care

- PPP : all care provided at PPP with case managers at installation
- Remote Care Option: currently used at MAMC, based on case management at installation, C-2 at State.
- CBHCI

BASIC CONCEPTS-CBHCI

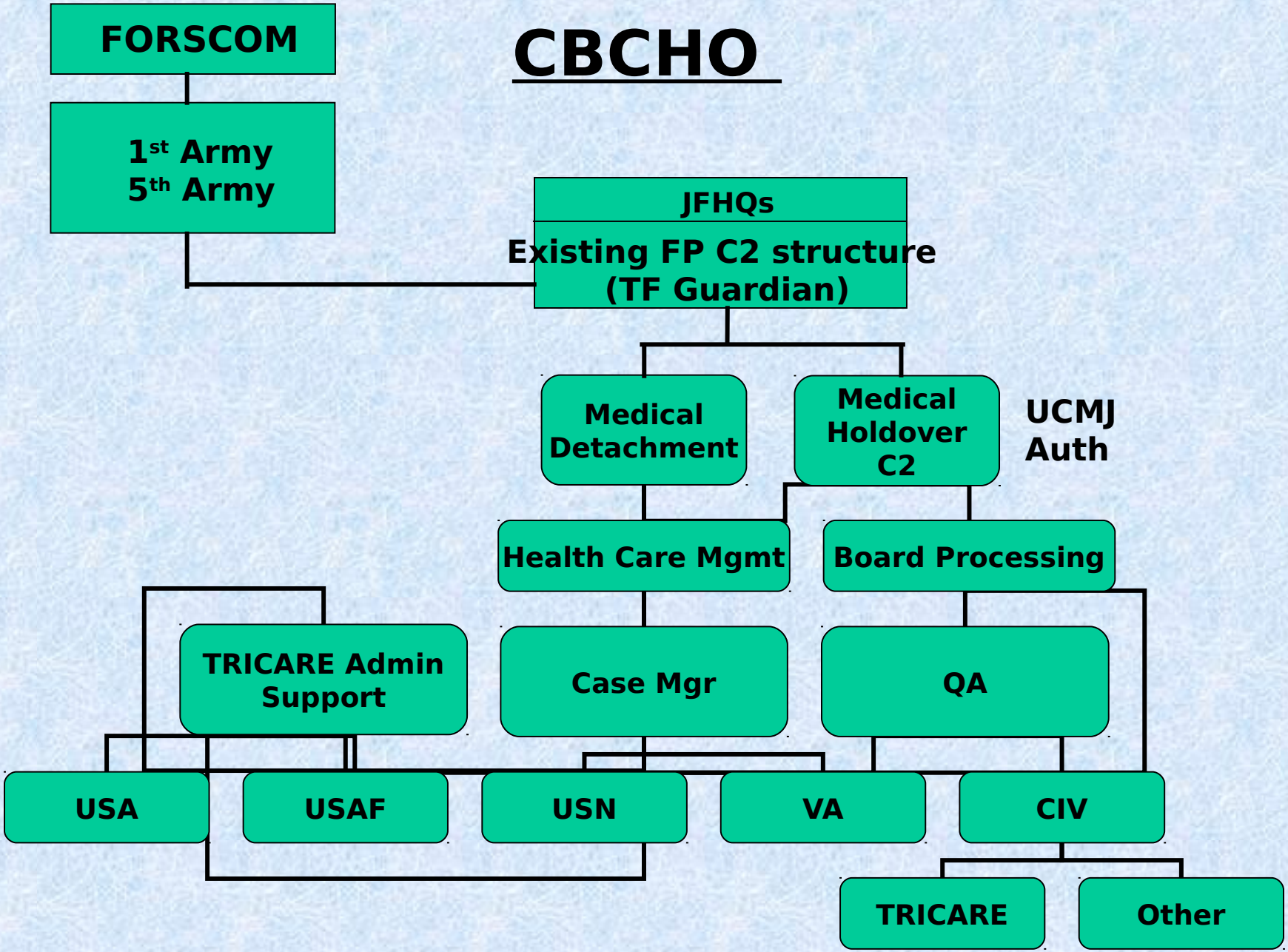
- Take care of soldiers
- Maintain accountability
- Every soldier every day

Background

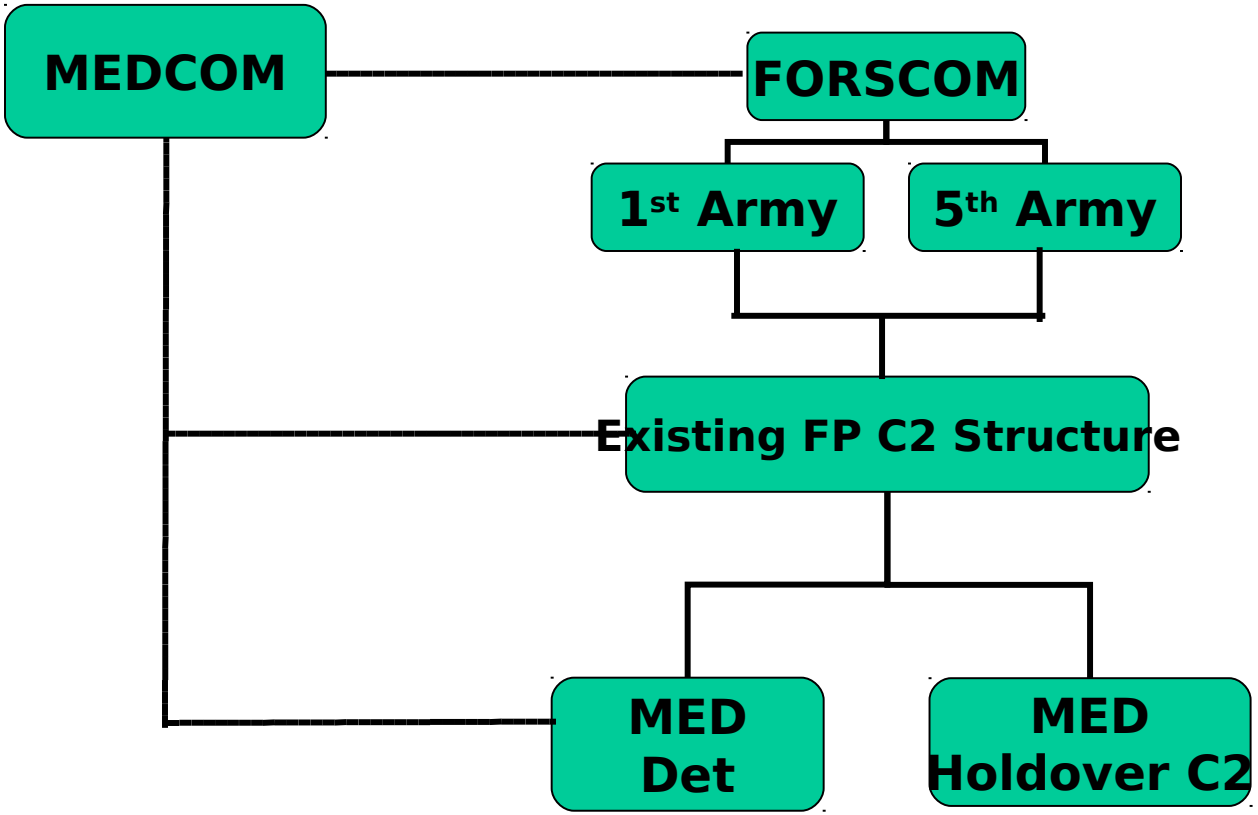
- Oct 03: Press exposed problems with Army's management of Medical Holdovers (about 5K soldiers)
  - Dr. Chu directed minimal housing standards and care access standards
  - Mr. Brownlee directed that non-deployable soldiers be re-fraded within 25 days of mobilization
- Spring 04: Working estimate for Medical Holdovers indicates that medical holdover soldiers will exceed MEDCOM's capacity of 5K
- LTG Blum offered National Guard assets to help manage medical holdovers "at home"

Objectives of Community Based Health Care Initiative

- Provide redeploying Soldiers the best and most appropriate health care expeditiously
- Respond to Soldier needs
- Expand available resources to serve medical holdover Soldiers
  - Use of other federal facilities (VA, other branches of the services)
  - Use of civilian facilities under TRICARE
- Obtain appropriate medical disposition
  - Accomplish required personnel action
    - Return to Duty (Return to unit or REFRAD)
    - PDES processing


FORSCOM
CBCHO
1st Army
5th Army
JFHQs
Existing FP C2 structure
(TF Guardian)
Medical Detachment
Medical Holdover C2
UCMJ Auth
Health Care Mgmt
Board Processing
TRICARE Admin Support
Case Mgr
QA
USA
USAF
USN
VA
CIV
TRICARE
Other

CBCHO Command and Control



Projected Manpower Requirements

- **CBHCO Medical Detachment:**
  - **1 MC Officer**
  - **1 AN Supervisor**
  - **10 AN Case Managers, (1:30 patients)**
  - **1 MS Patient Administrator**
  - **1 Transcriptionist (contract)**
  - **2 Clerks**
- **CBHCO C2 Detachment *(C2 directive "no priority is greater than a medical appointment":***
  - **1 Commander**
  - **1 First Sergeant**
  - **5 Platoon Sergeants**
  - **6 Personnel/Admin clerks**
    - Travel orders/TDY orders/ADME orders
  - **1 Supply Clerk**
  - **1 USAR Liaison (+/-)**

Policy/Regulatory Issues

- **MMSO**
  - Designation of Primary Care Managers
  - DEERS
  - Claims Processing
  - Travel Benefits
- **Orders/Authorities**
- **Housing at JFHQs(temp)**
  - Locations
  - Subsistence
  - Logistics support
- **Creation of directed Army data base (MODS)**
  - All aspects of medical holdovers
  - Accessible by all stakeholders

Training Required

Classes were conducted at PEC, 14-21 Feb

- **Medical Training***
  - **TRICARE/MMSO Overview**
  - **Board Processing Procedures (MEB/PEB)**
  - **Physical Evaluation Board Liaison Officers (PEBLO) Responsibilities**
    - Informal Counseling
    - Formal Counseling
  - **Chapter 3, AR 40-501, Standards of Medical Fitness and Profiling**
  - **AR 40-66, Medical Record Administration and Health Insurance Portability & Accountability Act (HIPPA) Concerns**
- **Command and Control**
  - **FORSCOM run mini commanders course**

***These topics are complex, technical, and many elements are governed by statute. It requires time to become proficient.**

Potential Risks with CBHCO Concept

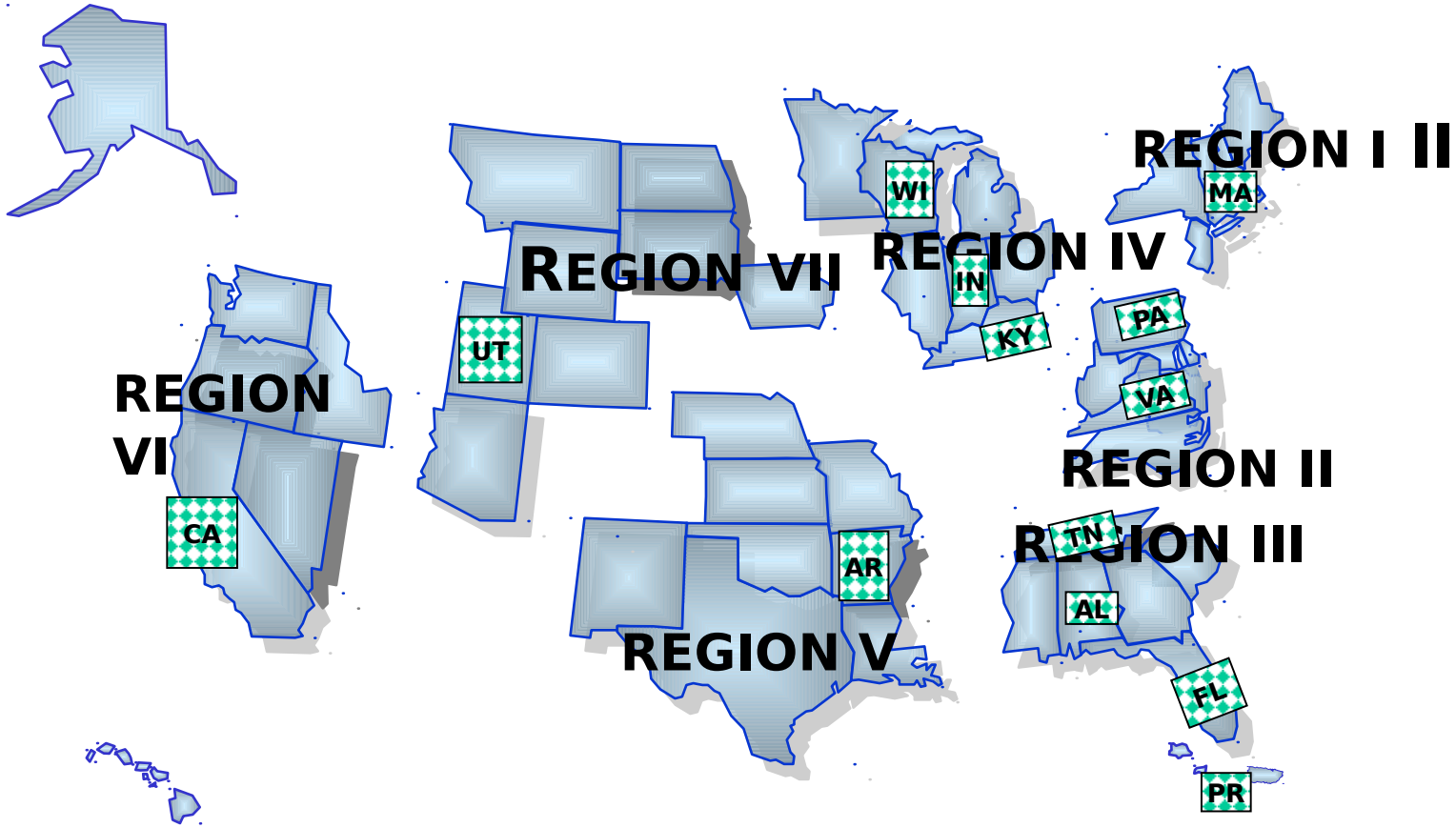
- **Variation in health care provided**
  - Varying regional and personal practice patterns exist
  - **Lack of knowledge of unique military needs**
- **Significant TRICARE (DHP) cost escalation is likely**
- **Program potentially motivates Soldiers to remain on Title 10**
  - Strong C2 mitigates
- **Complex technical details of TRICARE and Disability Board Processing will lead to some errors**
- **FORSCOM directed to accept mission over their non-concurrence**

Number of RC Soldiers Projected to Demobilize by State Jan -Jun 04

AK	35	GA	4,536	MA	1,332	NE	488	PR	3,076	WA	2,087
AL	3,703	GU	0	MD	2,989	NH	352	RI	283	WI	2,066
AR	1,215	HI	7	ME	195	NJ	1,261	SC	1,473	WV	1,286
AZ	1,621	IA	2,124	MI	808	NM	914	SD	720	WY	70
CA	5,317	ID	194	MN	2,101	NY	2,982	TN	1,874		
CO	2,225	IL	2,642	MO	3,090	NV	679	TX	5,090		
CT	928	IN	2,155	MS	1,836	OH	2,219	UT	1,557		
DC	261	KS	1,470	MT	442	OK	1,659	VA	2,372		
DE	400	KY	1,810	NC	2,188	OR	610	VI	0		
FL	5,316	LA	2,921	ND	652	PA	5,063	VT	228		

“Pilot States”

(arrayed on ARNG Medical Advisory Council Regions)



Request for Forces: 13 Med Hold Cells and 13 C2 Cells

Timeline

- CBHCO is the "pressure valve" in the Army's Medical Holdover mitigation strategy
- CBHCO will be operational using a phased approach:
  - FL will be operational on 1 March 04
  - MA, CA, AR and WI will be operational on 16 March 04*
  - The remaining sites will be on stand-by pending a need

  * site certification near completion(behind original projections)

Medical Holdovers is a politically charged issue…..many agencies are concerned about the execution of the CBHCO concept

Certification

- Per DA OPORD FORSCOM will certify all CBHCO sites prior to receiving medical holdover soldiers
- Certification team consists of FORSCOM, IMA, OTSG, NGB
- Currently all sites are certified except CA, pending re-evaluation

Comparison of Models of Care

- PPP: the known, the cheapest, limited surge capacity
- Remote Care option: long lines of communication with fragmenting of C-2 and case management
- CBHCO: most expensive, more comprehensive.

THE FUTURE

- Re-evaluation of CBHCI concept at 6 month mark
- Compare all 3 models of medical holdover care
- Holistic approach on evaluation (all players not just medical)
- Final answer may be some combination of elements of all three models

Conclusion

- The CBHCO is a “doable” concept
- A team (state-state, RC-AC) approach is necessary to execute smoothly
- The program is designed to take care of our soldiers